A. Coordination of Benefits

Wisconsin Medicaid is the payer of last resort for any Wisconsin Medicaid-covered service. If the recipient is covered under other health insurance (including Medicare), Wisconsin Medicaid reimburses that portion of the allowable cost remaining after exhausting all other insurance sources. Refer to Section IX of Part A of the provider handbook for more detailed information on services requiring insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

B. Medicare/ Wisconsin Medicaid Dual Entitlement

Recipients covered under both Medicare and Wisconsin Medicaid are called dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be submitted to Medicare *before* billing Wisconsin Medicaid.

If the recipient is covered by Medicare, but Medicare denied the claim, enter a Medicare disclaimer code on the claim form. Refer to Appendix 2 of this handbook for information on entering the Medicare disclaimer code. Providers are strongly encouraged to always obtain prior authorization for dual-entitlee recipients. This ensures Wisconsin Medicaid reimbursement if Medicare denies coverage.

C. QMB-Only Recipients

Qualified Medicare Beneficiary Only (QMB-only) recipients are only eligible for Wisconsin Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. (Since Medicare covers chiropractic services, claims submitted for QMB-only recipients are paid.)

D. Billed Amounts

Providers must bill their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, the usual and customary is the median of the individual provider's charge for the service when provided to non-Wisconsin Medicaid patients. Providers may not discriminate against Wisconsin Medicaid recipients by charging a higher fee for the service than is charged to a private-pay patient.

Do not reduce the billed amount by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the Wisconsin Medicaid-allowed payment.

E. Billing Specifications

Billing for Spells of Illness

To bill a new spell of illness:

- indicate the date of the new spell of illness in element 24A and procedure code 99201 in element 24D of the HCFA 1500 claim form. On the first claim for the new spell of illness, enter any charges for procedure code 99201 in element 24F;
- for subsequent claims related to the new spell of illness, indicate the date of that spell of illness in element 24A and procedure code 99201 in element 24D. Do not enter any charges in element 24F;
- refer to Section II-A of this handbook for documentation that must be included in the recipient's medical record.

Billing for X-Rays

Providers must not bill multiple radiology codes to describe a single service that was provided. Instead, bill the single, most appropriate Current Procedure Terminology (CPT-4) procedure code which describes the service. Refer to Appendix 5 of this handbook for allowable x-ray procedure codes.

E. Billing Specifications (continued)

When component procedure codes are billed rather than the appropriate CPT-4 procedure code for the sum of the separate procedures, the component procedure codes are cutback or denied.

Billing for Rental of Spinal Supports

When billing for the rental of spinal supports, enter the "FROM" date of service in element 24A. Leave the "TO" field blank and enter the total number of rental days in element 24G.

F. Claim Submission

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent can process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically can usually reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Paper Claim Submission

Submit procedure codes for chiropractic services using the HCFA 1500 claim form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Chiropractic services submitted on any other paper form than the HCFA 1500 claim form are denied.

The HCFA 1500 claim form is not provided by Wisconsin Medicaid or the fiscal agent. It is available from a number of forms suppliers. One source is:

State Medical Society Services, Inc.
PO Box 1109
Madison, WI 53701

(608) 257-6781 (Madison area)
(800) 362-9080 (Toll-free)

Mail completed HCFA 1500 claim forms to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

The fiscal agent must receive all claims for services rendered to eligible recipients within 365 days from the date of service. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late

Billing Appeals are in Section IX of Part A of the provider handbook.

G. Diagnosis Codes

Refer to Appendix 3 of this handbook for allowable chiropractic diagnosis codes.

Providers should note the following diagnosis code restrictions:

- Do not use codes with an "E" prefix as the primary or sole diagnosis on the HCFA 1500 claim form.
- Codes with an "M" prefix are not acceptable on the HCFA 1500 claim form.

H. Procedure Codes

HCFA Common Procedure Coding System (HCPCS) codes are required on the HCFA 1500 claim form. Claims or adjustments received without HCPCS codes are denied. Chiropractic HCPCS codes and their descriptions are listed in Appendix 5 of this handbook.

I. Follow-Up to Claim Submission

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. The fiscal agent takes no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A of the provider handbook includes detailed information about:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.